network
NETWORK 29 APRIL 2010

The Scots and scotch

From Robert Burns to The Simpsons the Scot has often been portrayed as a drunk. Sadly this is even more true now than it was in the past. But while it is true that drink has always been part of Scottish culture there is nothing fixed about our culture and the amount drunk, and the harm suffered has greatly increased in the last fifty years:

- alcohol related death rates in Scotland are twice as high as in England and Wales and have doubled over the last 15 years
- 15 of the 20 worst areas for male alcohol related deaths in the UK are in Scotland[1]
- more than 42,000 discharges from hospital per year relate to an alcohol-related admission[2]
- Scotland has one of the fastest growing chronic liver disease and cirrhosis death rates in the world[3]
- women in Scotland are as likely to die of liver cirrhosis as men in England
- in 2005, men who lived in the most deprived areas of Scotland were 6-7 times more likely to die an alcohol-related death than those in the least deprived areas
- enough alcohol was sold in Scotland in the last three years for which figures are available to enable every man and women over the age of 16 to exceed the sensible drinking guidelines in every single week
- alcohol misuse is estimated to cost Scotland £2.25 billion per year in extra services and lost productivity - £500 for every taxpayer.

> *"Some seem to think that it is a national duty to drink to excess, part of their Scottish identity"*

I work as a general practitioner in Glasgow and the daily evidence of my own eyes confirms the accuracy of these statistics. When I ask my patients how much they drink they often answer: "As much as I can afford." They are not joking. Some seem to think that it is a national duty to drink to excess, part of their Scottish identity. But it need not be like this. Cultures change, and ours has changed for the worse in the last fifty years with regard to alcohol consumption.

In their document *Changing Scotland's Relationship with Alcohol; A Framework for Action (2009)* Scotland's Scottish National Party (SNP) government has put forward a number of measures to reduce

alcohol related harm [4]. The main drivers on alcohol consumption have been referred to as the **'Three A**s'; accessibility, affordability and advertising. Controlling advertising, and especially a ban on sporting sponsorship, would make a big difference, but is a matter reserved for Westminster legislation. Accessibility is, to some extent, being tackled through the licensing act[5]. It is on affordability that the real effort is now centred. Banning discounts for multiple purchases has widespread support and will probably be passed. But it is minimum alcohol pricing that is the main measure and the one that has caused the most debate.

Research suggests that a 40p minimum price, combined with a ban on quantity discounts in off sales, would:

- save the lives of about 70 Scots in

1 Office of National Statistics (2007) Trends and Geographical Variations on Alcohol-Related Deaths in the UK 1991-2004

2 SMR01

3 Leon and McCambridge (2006) Changing Scotland's Relationship with Alcohol, The Lancet 367

4 http://www.scotland.gov.uk/Publications/2009/03/04144703/0

5 Licensing (Scotland) Act 2005 www.opsi.gov.uk/legislation/scotland/acts2005/asp_20050016_en_1

...continued overleaf

In this issue

We hope you enjoy this edition.

Editor

Don't forget to become a free member and receive regular clinical and policy updates - the newsletter can also be emailed to you – all for free www.smmgp.org.uk/membership

Editorial

We publish this edition of Network to coincide with the **Royal College of General Practitioner's 15 National Conference** in Glasgow on 22nd and 23rd April and we think you will notice a distinctly Scottish flavour to the newsletter! For the conference edition we like to give those of you who are unable to attend an impression of the event by asking speakers to write articles on the topics they are talking about; and for those of you who can make it, a idea of what is to come. The theme of this year's conference is *Integrating practice and policy: everyone's business* and a number of our articles reflect this theme: **Ewen Stewart** explores the different responses of the English and Scottish policy makers to prevent the harms associated with hepatitis C infection on **Page 10** and **Charles Lind** and **David Ewart** describe two very different responses from primary care to problematic drug use in Scotland within the same policy context on **page 8**. In these challenging economic times the role of local practitioners and stakeholders in shaping services has never been more important.

We would like to remind you of another event, **SMMGP's 5th National Primary Care Development Conference: Innovation in an Austere Climate** on Friday 15 October 2010, The Assembly Rooms, Newcastle-on-Tyne. The programme includes: inspiration for innovation in the current economic climate; problem solving sessions; examples of local and national innovation (workshops); opportunities to strengthen regional forums and networks. Don't miss it!

Enjoy this issue!

Kate Halliday
Network Editor

... *continued from page 1*

year one and 365 per year by year ten[6]

- reduce hospital admissions by 1,200 in year one and 3,700 per year by year ten
- result in a saving to the Scottish economy of £60 million in year one and £950 million over ten years, as a result of better health, fewer crimes and greater productivity.

Unfortunately all opposition parties have come out against minimum pricing and as the SNP is a minority administration the bill will not be passed. When Scottish Labour announced its opposition to minimum pricing it set up its own commission to consider measures to reduce alcohol related harm. Any viewer of Yes Minister must suspect that this is just an excuse for delay. The commission is chaired by a retired professor of education and contains mainly politicians rather than alcohol experts. Dr Richard Simpson, Scottish Labour's main spokesman on the subject, says that minimum pricing would punish low income people drinking within guidelines, and there would be massive cross border purchasing. While these are legitimate concerns surely the benefits would outweigh the problems and we have reached the time for action to be taken? The Scottish Liberal Democrats oppose minimum pricing, yet the Westminster party supports it and Willie Rennie, a Scottish Liberal Democrat MP is campaigning in support of it. Even within the conservatives Iain Duncan Smith and a few other MPs are supporting it.

Labour's commission should report in the summer, but they have said that they will not support minimum pricing even if the commission comes out in favour of it. Let us hope that some effective action will be taken soon to tackle Scotland's alcohol problem.

Richard Watson Clinical Lead,
Substance Misuse, RCGP Scotland

6 Meier, P et al. (2009) Model-Based Appraisal of Alcohol Minimum Pricing and Off-Licensed Trade Discount Bans in Scotland: A Scottish adaptation of the Sheffield Alcohol Policy Model version 2. Sheffield: Sheffield University.
http://www.scotland.gov.uk/Publications/2009/09/24131201/0

What we can offer to the small minority of patients who do not respond to the evidence based treatments of buprenorphine and methadone? *Jack Leach* discusses our options. *Ed.*

Alternatives to methadone and buprenorphine

Introduction

Methadone and buprenophine are effective treatment components for opiate dependence, endorsed by National Institute for Clinical Excellence and the Department of Health prescribing guidelines[1,2]. However, controlled trials and longitudinal studies have found that a substantial minority in treatment programmes do not appear to benefit significantly from these medications compared to comparison groups[3]. Is there a place in these "methadone and buprenorphine resistant" opiate users to use alternative treatments, and if so what alternative, with what selection process and under what circumstances?

Treatment failure

In practice there may be a number of reasons why treatment is thought not to be working and it is worth remembering that it is not always possible to make useful comparisons between how the patient would do in treatment as compared to them not being in treatment. Not doing well may be judged in a number of ways, including:

- continuing illegal drug use, particularly injecting
- continuing poor mental and physical health consequent on illicit drug use
- continuing poor social situation and personal relationships consequent on illicit drug use.

Treatment may not be working due to inadequate doses of substitute medication and inadequate psychosocial support which is an essential element of effective treatment[4].

1 National Institute for Clinical Excellence (2007). Methadone and buprenorphine for the management of opioid dependence. NICE Technology appraisal guidance 114.

2 Department of Health (2007). Drug misuse and dependence: guidelines on clinical management 2007.

3 Ward J, Mattick R, Hall W (editors) (1998). Methadone maintenance and other opioid replacement therapies. Amsterdam:Harwood Academic Publishers.

4 National Institute for Clinical Excellence (2007). Drug misuse: psychosocial interventions. National clinical practice guidelines 51.

Expectations of treatment by patient and by the service may be too high.

Identifying blocks and optimising treatment

Clearly the first approach is to work with the client to identify blocks to successful treatment and try to rectify them, optimising the methadone or buprenorphine treatment programme. There may be a temporary bad patch or it may be part of a general trend. However, if after all efforts have been made and the patient continues not to do well, what next? One way forward might be to prescribe an alternative to methadone or buprenorphine.

Alternative opioid substitution medication

Many services have constraints about prescribing buprenorphine, either on its own or in combination with naloxone (Suboxone), never mind being able to prescribe other alternatives. However if you were able to, what might you consider? A number of alternative opioids have been found to reduce illegal opiate use in study programmes. These fall into two categories:

1. Altenative oral opioids, including dihydrocodeine and oral morphine sulphate preparations
2. Injectable opioids, including injectable methadone and diamorphine.

Other opioids such as dipipanone and palfium, and alternative delivery systems such as fentanyl and buprenorphine cutaneous patches, and rectal formulations have not been evaluated.

Before considering alternatives, I believe there are two crucial largely unanswered questions:

1. Is there something special about methadone and buprenorphine that makes them unique as substitutes for the treatment of opiate dependence?
2. 2. If not, would other opioids work for the patients for whom methadone and buprenorphine do not work, or do they only work in patients for whom these medications do work as well?

The research supporting the use of diamorphine, dihydrocodeine and oral morphine sulphate does not show a clear advantage overall of either methadone or of these alternatives. Only diamorphine studies from the Netherlands and Germany tried to evaluate whether adding diamorphine to methadone improved outcomes in treatment resistant clients. The results do not give a clear interpretation.

When considering alternatives, issues of safety, cost and diversion need to be borne in mind. Table 1 estimates these dimensions relative to methadone:

TABLE 1: Comparisons between different alternatives to methadone

OPIOID	SAFETY	DRUG COST	DIVERSION POTENTIAL
Dihydrocodeine	No greater risk than methadone but because it is shorter acting it is difficult to supervise and it is also reported to reinforce drug taking	Equivalent cost	Comparable with methadone
Oral morphine sulphate preparations	No greater risk than methadone. Longer acting preparations could be given by daily supervised consumption	Around 3 times the cost	Comparable with methadone
Methadone for injection	Assumed there is greater risk of infection, thrombo-embolism and accidental overdose	Around 1.5 times the cost	Assumed to be greater than methadone mixture
Diamorphine for injection	Assumed there is greater risk of infection, thrombo-embolism and accidental overdose	Around 5 times the cost	Assumed to be much greater that methadone

Dosing and dose conversion values

There are differences in opinion regarding relative dose conversion as there is little objective research and most views are based on clinical experience and rhetoric, usually from palliative care and chronic pain management clinicians rather than substance misuse practitioners. For example, some in the substance misuse field use a conversion value between methadone and oral morphine sulphate preparations of between 1mg of methadone to 1-3mg of oral morphine sulphate per day, whereas the research papers found observed conversion rates of around 1mg of methadone to 4-5mg of oral morphine sulphate, and palliative care guidelines suggest 1mg of methadone is more closely equivalent to 6-9mg of oral morphine sulphate.

Monitoring treatment programmes

Although the value of drug screening for managing opiate treatment programmes has been questioned [3] it continues to be widely used. Routine local laboratory testing generally does not distinguish prescribed morphine or diamorphine from street heroin; all three will show as 'opiate positive'. However both street and prescribed diamorphine will give rise to 6-monoacetyl morphine which morphine does not, and is detectable in urine for a few hours after administration (the exact time depending on the amount taken). Street heroin can also be distinguished from morphine and pharmaceutical diamorphine by specialist laboratories. This is due to the fact that street heroin is derived directly from poppy sap, giving rise to a number of products which are not seen in pharmaceutical diamorphiine or morphine, particularly 6-acetyl codeine, and metabolites of noscapine and papaverine. A negative test for any of these does not necessarily mean that a person has NOT taken heroin because they have short half-lives, but can be useful information if they are positive.

Discussion

The choice of alternatives are limited but each could have its place in clinical practice. Use of dihydrocodeine in Edinburgh has shown that it can be useful[5], but probably has little advantage over methadone except in people who don't want methadone. Diamorphine definitely has a place in opioid dependence treatment and its effectiveness has been shown in the Randomised Injecting Opioid Treatment Trial (RIOTT) though perhaps only in a select group of treatment-resistant injectors. Oral morphine[6] has long had its place in many European countries, especially Austria where about a third of patients are on morphine and perhaps it is this drug that may increase the capacity of our limited toolbox.

Dr Jack Leach
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Lead Doctor Smithfield Services, Manchester
National RCGP Co-Lead for Alcohol

5 Robertson JR, Raab GM, Bruce M, McKenzie JS, Storkey HR and Salter A (2006) Addressing the Efficacy of Dihydrocodeine Versus Methadone as an Alternative Maintenance Treatment for Opiate Dependence: A Randomized Controlled Trial. *Addiction* 101 (12), 1752_1759.

6 Dominik Kraigher (2005) Use of Slow-Release Oral Morphine for the Treatment of Opioid Dependence European Addiction Research 2005 (11) 145-151

David McCartney **highlights the importance of supporting people in their recovery and how we can do this. He argues that it is essential that practitioners are aware of the growing number of recovery services available to patients, that we should use a proactive approach, and that primary care is the perfect setting in which to support people in their recovery journeys. For more on Recovery Oriented Integrated Systems, see Mark Gilman's article on page 12. Ed.**

Recovery voices get louder

Recovery, the new kid in town

The emphasis of the UK government[1] and the devolved administrations of Scotland and Wales on recovery has signalled a clear change in policy which has raised the bar for those of us involved in providing treatment to problem drug users.

If we are to support people towards full recovery, we will need to learn the language of recovery, understand the nuts and bolts of the recovery process and be able to listen to the voices of those who have already been there. Primary care practitioners are in a unique position to do this, but we need to be informed as to what it is all about and have a good understanding of what is already happening.

The Scottish Government defines recovery as "a process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society"[2]. The Road to Recovery policy sets recovery as the goal of all treatment services as does the 2008 UK Drug Policy document which states that "the goal of all treatment for drug users is to achieve abstinence from their drug – or drugs – of dependency"[3].

Other definitions, such as those of the Betty Ford Consensus Panel[4] and the UK Drug Policy Commission[5] also embrace the ideals of moving on to a full and fulfilled life. Recovery as an established notion is much better developed in the United States with several areas establishing recovery oriented integrated systems of care[6]. Many are agreed that the essentials of recovery are hope and aspiration and this is certainly the starting place for recovery in the UK. The mental health field is accumulating an evidence base for recovery oriented interventions.

> ***"Connecting patients to communities of recovery, like Narcotics Anonymous and Cocaine Anonymous should be done in an assertive fashion; not only with a leaflet, but by arranging for a support worker or another recovering person to take them"***

Recovery voices

Government may be calling for a change to our approach, but there are many other voices calling for recovery to be at the heart of treatment and support in the UK.

In March 2010 the Scottish Drugs Recovery Consortium was launched. Its role will be to "identify, support and coordinate the incredible work that is already going on across Scotland, much of it unheralded and unfunded, to ensure that there is consistency and coherence in delivering the recovery agenda in Scotland"[7].

The UK Recovery Academy was formed in 2009. This developed out of an awareness of the recent interest around recovery, but also from frustration that this was "not reflected in research publications, publicly funded research or even evaluations of the recovery model or explorations of what it means for users, professionals or communities"[8].

The members of the Academy aim to evidence the effectiveness of recovery and map personal and community growth and transformation and to chart success. Over a hundred researchers, clinicians, professionals, clients and commissioners are already signed up to pursue these aims. The Academy recognises the recovering person as expert in the process.

Grassroots movements

The *Wired In to Recovery* online community was launched in 2008 in order to empower people to tackle alcohol and drug problems[9]. A form of virtual mutual aid, it aims to bring people together with the common purpose of helping themselves and others. It also aspires to tackle stigma. With over a thousand members and areas for recovering people, families and professionals it is a very active site and source of much debate and much support.

The UK has already seen the first recovery marches/walks. These aim to put a face to recovery, to overcome stigma and to demonstrate to others struggling with drugs and alcohol that recovery is a reality. In 2009, there were two of these: one in Inverness and another in Liverpool. The latter attracted over 1000 people. On the 25th September 2010, the second UK National walk will take place in Glasgow[10]. This is planned to be an annual event with the 2011 walk taking place in London.

This last year has seen the emergence of several community-led recovery organisations. One to watch is the UK Recovery Federation (UKRF). Grassroots-led, it will hold a conference in Tameside, Manchester in May 2010. The UKRF will assist in the development of 'Recovery Oriented Integrated Systems' (ROIS) but will principally focus on the raising and maintaining of 'recovery capital/social capital' within recovery communities. In particular it will implement a framework

1 HM Government (2008) Drugs: Protecting families and communities: The 2008 drug strategy. HM Government: London.

2 Scottish Government (2008) The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem (vi). Scottish Government: Edinburgh

3 HM Government (2008) Drugs: protecting families and communities. The 2008 Drug Strategy.

4 The Betty Ford Institute Consensus Panel (2007) Journal of Substance Abuse Treatment 33;221–228

5 United Kingdom Drugs Policy Consortium (2008) Recovery Consensus Group http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf

6 Lamb R, Evans AC, White W, (2009) The Role of Partnership in Recovery-Oriented Systems of care: The Philadelphia Experience http://ireta.org/resources/RoleOfPartnershipInRecoveryOriented-Care2009.pdf

7 Scottish Drugs Recovery Consortium, (2010) SDRC goes live, (letter), SDRC, Glasgow

8 Bamber S, Best D (2009) A New Way, Drink & Drug News, 13 July, London

9 www.wiredin.org.uk

10 UK Recovery Walk 2010, http://wiredin.org.uk/users-ex-users/community/blog/entry/7516/uk-recovery-walk-2010-marching-on/

to enable Community-Led Emerging Recovery Communities (CEROs) and Recovery Networks to grow and expand across the UK[11].

The Serenity Cafe[12] in Edinburgh is a further community development. It offers a safe, alcohol and drug free social space where the recovery community can gather to celebrate and have fun. The Serenity Café has direct links to the Lothians and Edinburgh Abstinence Programme, a formal treatment provider locally. Other initiatives like this are likely to develop across the UK as recovery advocacy grows.

Mutual aid

Of course recovery from dependent drug and alcohol use is not new. "Natural" recovery is a recognised phenomenon[13] and it is likely that many folk recover without any formal treatment. A significant proportion are likely to recover through support gained from mutual aid (self-help) groups.

Mutual aid has a robust evidence base[14], though it does not lend itself to randomised controlled trials. Signposting to mutual aid organisations is recommended by National Institute for Health and Clinical Excellence and the 2007 Clinical Guidelines [15] [16] which state: "Staff should routinely provide people who misuse drugs with information about self-help groups. These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous". It is worth attending an open meeting to find out more.

We have a solid tradition of mutual aid with Alcoholics Anonymous (AA) hosting more than four and a half thousand meetings every week in the UK. In the last two years alone, AA members have opened around 600 new meetings. Narcotics Anonymous holds almost a thousand meetings a week and is growing rapidly. In 1992, Cocaine Anonymous held its first meeting in London. Today there are 230 meetings across the country. SMART Recovery[17] utilises a cognitive behavioural therapy approach and is a relative newcomer with around 30 weekly meetings in the country. There is a lot of interest in the approach and it is likely to grow. Community and mutual aid activities can be diverse, like the Serenity United football team in Edinburgh or the LEAP guitar and chess clubs.

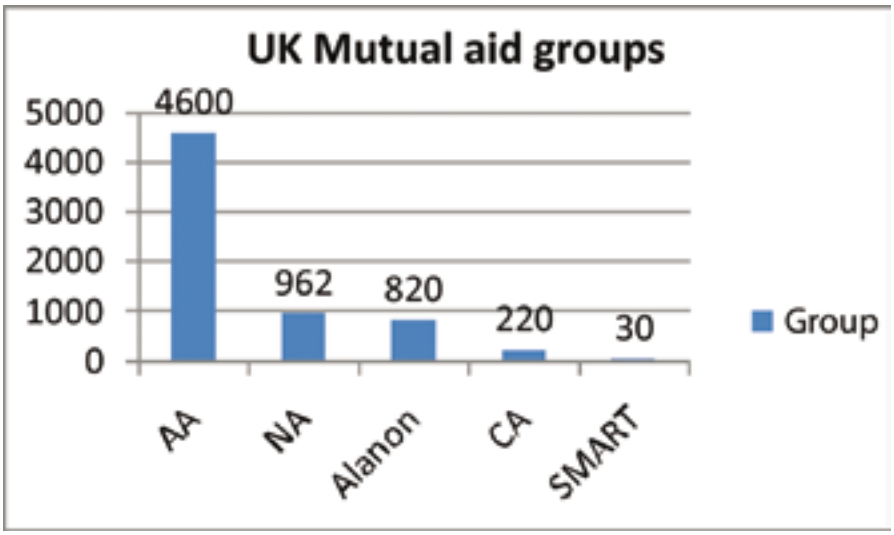


Figure 1 AA = Alcoholics Anonymous; NA = Narcotics Anonymous; CA = Cocaine Anonymous

Challenges and opportunities for practitioners

While the National Treatment Agency and Substance Misuse Management in General Practice have supported recovery as a treatment goal for patients, not all practitioners do so. There are many arguments raised against recovery[18] and these need to be addressed. We know that people do recover[19] and our challenge is to let our clients/patients know this and to support them to recover safely.

Connecting patients to communities of recovery, like Narcotics Anonymous and Cocaine Anonymous should be done in an assertive fashion; not only with a leaflet, but by arranging for a support worker or another recovering person to take them. Arranging this during a consultation is possible through having the patient call the appropriate help line. There is good evidence to support this approach[20].

Knowing what recovery-focussed treatment options are locally available is essential. These are likely to integrate psychological therapies, housing, training, education and employment, and practice referral to mutual aid. For those undertaking detoxification from opiates, education around loss of tolerance and harm reduction advice is crucial. We need also to increase understanding around what constitutes medication assisted recovery for those who do not want to move to abstinence and to grasp that treatment and recovery are complimentary.

Listening to the recovery voices

While there is a governmental encouragement for treatment providers to move towards a recovery model, there is also a push from the bottom up. In the UK, recovery voices are speaking out. Their message is clear. Recovery is possible; let's make it more possible. Primary care professionals are ideally placed to help, but we need to learn the language and pathways of recovery in partnership with patients. Culture change is likely to be required to allow this to happen.

David McCartney Clinical Lead LEAP, NHS Lothian

11 http://wiredin.org.uk/community/blog/entry/7211/uk-recovery-federation-consultation-paper

12 Serenity Cafe (2010) http://www.serenitycafe.org.uk/page3.htm

13 Granfield R. & Cloud, W. (2001) The elephant that no one sees: natural recovery among middle-class addicts. *Journal of Drug Issues*, 26(1), 45-61

14 Humphreys, K. (2004) Circles of Recovery: Self-help organisations for addictions. Cambridge University Press: Cambridge.

15 National Institute for Clinical Excellence (2007). Methadone and buprenorphine for the management of opioid dependence. NICE Technology appraisal guidance 114.

16 Department of Health (2007). Drug misuse and dependence: guidelines on clinical management 2007.

17 http://www.smartrecovery.org/

18 Best D, Bamber S, Battersby A, Gilman M, Groshkova T, Honor S, McCartney D, Yates R, White W, (2010) Recovery and straw men: An analysis of the objections raised to the transition to a recovery model in UK addiction services (in press)

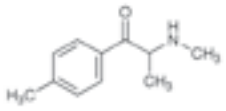
19 Warner R, (2010) Does the scientific evidence support the recovery model? The Psychiatrist 34:3-5

20 Timko, C., & Benedetti, A., Billow R., (2006) Intensive referral to 12-step self-help groups and 6-month substance use disorder outcomes. *Addiction 101,* 678-688

There has been an explosion of interest in mephedrone in the last few weeks, prompted by a number of unconfirmed deaths of users the drug. *Adam Winstock* and *John Marsden* take us through a brief history of mephedrone, its effects, and offer some tips for basic harm reduction advice. Since the writing of this article, as predicted by the authors, mephedrone has been banned. Ed.

Mephedrone – a brief clinical update for GPs

What is it?



Mephedrone (4-Methylmethcathinone) is an amphetamine-like stimulant. It is a member of the cathinone and phenethylamine chemical classes and is derived from the khat plant (*Catha edulis)*. Along with other cathinone compounds (including methylone [4-methylenedioxy-N-methylcathinone] and butylone [3,4-benzodioxolylbutanamine]), mephedrone is not currently controlled under the Misuse of Drugs Act. In the past 18 months, there have been signs of a rapid increase in use of mephedrone and other 'legal highs' among certain population groups, and there have been several associated, but unconfirmed, fatalities.

Why now?

Legal highs have been available for decades but it is only in recent years that their range and potency, combined with the rise in web based marketing, has allowed them a profitable foothold in the market[1]. Some researchers have suggested its appearance and popularity is in part due to current dissatisfaction among regular stimulant users with the cocaine and ecstasy market[2]. That mephedrone may substitute for these traditional stimulant drugs is certainly possible given a similar effect profile.

What is it sold as?

Mephedrone is widely available on the internet in the UK and costs approximately £10/gram (one quarter the price of cocaine in the UK). Mephedrone has several colloquial names including Miaow, 4-MMC, Meph and TopCat. It has become popular among those already using illicit stimulant drugs such those associated with the clubbing scene[3] but also appears to be used among the wider community such as pub goers[2]. Use among these sentinel populations may predict future appeal to the wider community[4]. While distributors mark their product as *not for human consumption* or as *bath salts* or *plant feeder*, control under the Medicines Act is not possible. This obfuscation of the true intended purpose of the substance leaves users with little more than chat room and peer user guidance (which can in some cases be very helpful) regarding dosing and safer use.

How is it used?

Mephedrone is a water soluble powder and is usually taken intranasally or orally, and rarely by injection. Individual doses vary from 100-250mg, and several grams may be consumed across a single session. It appears likely that tolerance develops to its effects such that more frequent use is likely to lead to an increase in doses being consumed.

What does it do?

Given its structure and reported effects, mephedrone probably leads to the release and/ or inhibition of reuptake of monoamine neurotransmitters. Subjective effects are dose-related and include euphoria, increased energy, increased libido, sweating, tachycardia, headache and teeth grinding. Little is known about its effects in overdose but emergency medicine case reports point to a cluster of cardio-vascular signs with agitation, and sometimes paranoid-type hallucinations.

And the health risks?

Little is known about toxicity, pharmacology and longer term effects. It is likely that a mephedrone induced psychosis may be experienced by heavy chronic users and associated with prolonged insomnia in those also vulnerable to such episodes. A recent study[5] suggests that the drug gives a high of quality and duration that is better than cocaine. The same study suggests that that abuse liability may be higher with the intranasal route and that this may lead to higher doses being consumed more frequently. There is no information available on neurotoxicity or the long term consequences of use.

> ***"Little is known about its effects in overdose but emergency medicine case reports point to a cluster of cardio-vascular signs with agitation, and sometimes paranoid-type hallucinations"***

What do I ask about and what advice should I give?

Ask users about amounts used, route of use, frequency of use and intoxication related behaviours. Referral to a specialist may be indicated where the patient reports using several times a week and reports signs of tolerance, loss of control, psychological distress, preoccupation, hallucination, agitation, persistent low mood and craving. It is important to screen for high risk intoxication related behaviours.

Harm reduction advice

In terms of harm reduction it is difficult to provide anything apart from commonsense advice that would accompany the use of any psychoactive stimulant (see box 1); to avoid taking the drug on your own, to ensure someone not drug affected is near to hand, not to use too often, to avoid developing tolerance, not to snort, not to mix with other substances and to avoid prolonged periods of insomnia.

What is likely to happen next?

Both the UK Advisory Council on the Misuse of Drugs and the European Monitoring Centre on Drugs and Drug Addiction are gathering evidence on mephedrone risks and associated harms. It is likely that increased controls will follow these assessments in the near future. Whether this is the most appropriate response to reduce use and the risk of harm is uncertain. Media and web based reports suggest it is possible that there are many people pre-emptively stockpiling this drug, planning to benefit

1 Winstock and Ramsey 2010 in press

2 Measham F, Moore K, Newcombe R, Welch Z. (2010) Tweaking, bombing, dabbing, and stockpiling: The emergence of mephedrone and the perversity of prohibition. Drugs and Alcohol Today; 2010 10(1):

3 Mixmag Drug survey Jan 2010 Winstock and Mitcheson

4 Winstock AR, Griffiths P, Stewart D. (2001) Drugs and the dance music scene: A survey of current drug use patterns among a sample of dance music enthusiasts in the UK. Drug Alcohol Depend (2001) Sep 1;64(1):9-17 (2001)

5 Mixmag Drug Survey 2010

from expected legislation that that will remove currently available and financially attractive legal routes of purchase. How effective legislation will be at curtailing internet marketing and distribution of these substances is unknown, as is the consequences upon the current low quality illicit stimulant market.

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Dr John Marsden, Psychologist and Senior Lecturer in Addictive Behaviour, National Addiction Centre

BOX 1 Possible harm reduction advice, interactions and precautions

Condition/behaviour	Probable contraindications/ precautions	Possible consequences	Advice
Health conditions	Central nervous system (CNS) Cardio-vascular system (CVS) conditions/ medications	Exacerbation of arrthymias or other underlying CVS conditions, possible lowering of seizure thresholds	Avoid for those with pre-existing conditions, avoid overheating and dehydration
Prescribed medications	CNS, CVS, antidepressants	May possibly result in withdrawal that may be confused with depression, may compromise efficacy of mood stabilising and lifting medications	Avoid use if taking antidepressants or if concerned with diagnosis of depression
Alcohol	Reduced subjective psychomotor impairments with alcohol	Permit greater amounts of alcohol to be consumed and also greater amounts of alcohol	Avoid combined use
Other stimulant drugs	May increase risk of adverse CVS/CNS/ psychiatric and hyperthermia events	Avoid combination of poly stimulant use	Do not mix with other stimulant drugs
Development of tolerance	Suggestive of regular use and places individual at risk of dependence	Withdrawal upon cessation and other broader psychosocial and physical risks	Avoid use more regularly than every one to two weeks, avoid intranasal route of use

Martyn Hull **takes us through the development of the Royal College of General Practitioners Certificate in the Management of Drug Misuse, the impact it has had on the drugs field, and the reasons why all primary care clinicians should complete the course. Ed.**

The RCGP Certificate in the Management of Drug Misuse Part 1: the story so far

Part 1 of the Royal College of General Practitioners (RCGP) Certificate in the Management of Drug Misuse was launched at the 9th RCGP National Management of Drug Users in Primary Care Conference in May 2004. Accredited by the RCGP, it stands alone in delivering first class training in substance misuse management in primary care, standardised nationally and delivered to a multi-disciplinary cohort. It has been hugely successful since its launch and is recognised as being an instrumental component in the mainstreaming of drug treatment in primary care. Nowadays, compared to the situation prior to the launch of the Certificate, many more GPs and allied professionals are receiving excellent, validated, specific and confidence-building education, and are consequently carrying out high quality drug treatment in their day-to-day practice.

It is a multi-disciplinary course, ideal for practitioners working at a generalist level as part of a shared care scheme, and as part of locally or nationally enhanced services. It is mapped to the Drug and Alcohol National Occupational Standards (DANOS) competencies, and is delivered in two stages: the completion of two e-modules and a face-to-face day facilitated by trainer(s) with specialist knowledge in the field. The face-to-face day offers a variety of learning activities; lectures, facilitated group work / case studies, and the opportunity to bring queries, concerns and learning needs to discuss with peers and trainers who are expert in the field. Participants are expected to interact, are given pre-course reading material including standard texts, and are signposted to ongoing training opportunities after completion of the course.

The Certificate is delivered nationally (centrally coordinated by the RCGP Substance Misuse Unit), and also via a network of trainers across the country. This enables the formation of local links within the field of substance misuse at a level lower then the specialist networks already developed. Such local integration is a vital component in the paradigm shift required to continue to move substance misuse treatment to the core of primary care.

There are two separate components to the Certificate Part 1. The Generic Part 1 was joined by a specific Secure Environments version, launched in November 2006. This was in response to the recognised need for provision of drug treatment in prisons, and the specific challenge that this presents. Since 2004, over 10000 delegates have successfully completed the Certificate, including over 1000 achieving the Secure Environments Certificate.

Initially introduced as an adjunct to the more in-depth Certificate (now the Part 2) that had been in place for a few years,

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Charles Lind **and** ***David Ewart*** **describe two very different responses from primary care in Scotland to the same problem: the rise of drug use and its associated harms in the 1980s and 90s. Their stories give insight into the central importance that local key players have in the development of services.** Ed.

Making the most of what you've got

This article outlines two very different local responses to the rise in substance misuse and its associated problems in two different areas of Scotland.

Shared care for drug users is a much used term but each shared care service will have come up with different models depending on what elements of care are shared and how much of the share lies in either primary or secondary care. Services often evolve by a serendipitous route depending on local events and the vision and enthusiasm of a few key players. They will tell stories of having had to make do with very little and building services over time by badgering, or shaming, commissioners into action. Although many drug services are now protected by mainstream funding, others struggle on with commitments to only short term resources and a reliance on the voluntary service to paper over gaps in provision.

The Road to Recovery[1] sets the scene for what is expected of National Health Service Boards when it says they must:

- ensure an appropriate level of service capacity, given local needs
- work with local authorities and other partners to provide coordinated and holistic care
- have data collection systems in place and ongoing evaluation of treatment outcomes.

How this is achieved depends on what structures are already in place, how well they are supported by systems that allow for data collection, audit and evaluation, and the willingness of local commissioners to invest in this work.

Ayrshire and Arran

The latest prevalence data on problem drug use (2009) suggest that Ayrshire has one of the most extreme drug problems in Scotland. The substitute prescribing programme in Ayrshire was started in 1990 in response firstly to growing concern about the rapidly increasing use of intravenous opioids and benzodiazepines, and secondly, due to clear evidence of alarming injecting practices.

By the mid 1990s the programme had grown to such a degree that it was thought advisable by the Director of Public Health to request the involvement of GPs. At this time the main focus of primary care power, the GP subcommittee, asked for a meeting to help them better understand the issues as they felt that the problem was not particularly severe and that the response had become disproportionate. Over the next eighteen months the Clinical Director of Addiction Services met with the GP subcommittee twice. At the first meeting it became clear that this body had little sympathy for the issues involved and had no intention of allowing GPs to become involved in a matter that they felt was a social and not a medical issue.

> ***"Services often evolve by a serendipitous route depending on local events and the vision and enthusiasm of a few key players"***

At the second meeting their position had relaxed slightly and they allowed that there was indeed a medical component but that the response to this should lie entirely within secondary care. They felt that primary care had no part to play despite the clear national momentum towards sharing care arrangements between primary and secondary care. This view remains the official position of the GP subcommittee and, as such is supported by far and away the majority of Ayrshire GPs. There is currently one GP in Ayrshire who prescribes methadone for two of his patients and two GPs work on a sessional basis within the substitute prescribing service. The rest have declined any involvement. The substitute prescribing service and all of its ancillary components therefore rest entirely within the specialist sector (this contrasts with the opiate and alcohol home detoxification service which essentially rests within primary care and which is heavily used and very positively evaluated by general practitioners).

The advantages to this stand alone model for substitute prescribing are that strategic control over prescribing and support issues can be absolutely uniform across the county and that, especially in the areas of psychiatric co-morbidity (given the strong psychiatric constituency of the team) and the detection and treatment of blood borne viruses (given the close working relationships with infectious diseases), treatment can be very effectively joined up. The disadvantages however are legion. Services remain separated and stigmatised. The group of patients who are absolutely stable have to continue to be involved in the Addiction Service. The lack of expertise within the service with regard to general medical services and the worryingly frequent disinclination of some primary care practitioners to provide some aspects of this (especially in the areas of pain relief and mild to moderate psychological problems) expose an already health impaired patient group to further unnecessary problems. This seems to have its roots in a widely held suspicion as to the patient's 'real' motive. Thus those professionals who could reasonably be expected to have the closest and most complete understanding of patient needs become entirely disconnected (other than through correspondence) from what can be the most intense, difficult and lengthy therapeutic experience of a patient's life. There are of course a number of honourable exceptions to this attitudinal difficulty but the perception of both the service and the clients is negative, and a significant proportion of primary care remains at best disinterested and at worst overtly hostile.

A further difficulty is the unusually obvious nature of spend, given that the entire budget (including a large proportion of psychotropic drugs that might normally be expected to emanate from primary care) is held within one service. This seems to make it more vulnerable to Health Board scrutiny. For the last three years the service has been supporting between 1800 and 2100 clients, and in the process experiencing serious financial difficulties. For most of this time new admissions have been

1 Scottish Government (2008) The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem (vi). Scottish Government: Edinburgh

limited to pregnant women, those with childcare issues and those with serious mental health problems. For six months in 2009-10 there was an absolute bar on new substitute prescribing which thankfully now seems to have been resolved. Despite repeated representations to the Health Board about the iniquities of this as well as the likely health cost, this resulted in the building up of a large and rapidly expanding waiting list comprising some 350 people (with all the health problems implicit in this), most of whom at that time had no hope of getting into treatment. It is hard to imagine any other specialty being expected to work under such conditions and hard to imagine this being possible if GPs were to be more deeply involved in providing care.

A recent piece of research conducted by the Scottish Drugs Forum amongst service users suggested that whilst most were happy with their specialist care they were frequently critical of their primary care providers, despite this not being a question that was asked.

The Addiction Service remains committed to assessing and treating patients until the point at which their drug use becomes stable but has, by now, a large cohort of clients who have been stable in every conceivable sense of the word for many years. Our policy of insisting that all those in receipt of a prescription have to accept an accompanying package of care no matter where in the programme they happen to be, means that many are in receipt of a degree of support that they don't need and that in some cases becomes inconvenient and intrusive. It is this group that might most benefit from their GPs taking over their prescribing needs with whatever support from the service is felt to be appropriate and with the proviso that instability will be dealt with by immediate return to the Addiction Service. There seems little hope however of this becoming a reality in the near future.

The Lothian model of GP care for drug using patients.

The history

The Lothian model grew out of the twin epidemics that hit the area in the 1980s. The first was the injecting epidemic, fuelled by the increased availability of heroin and the fragmentation of the social structure in the city's peripheral housing estates leaving young people without employment and with damaged prospects. The second epidemic was HIV which escalated in the injecting population, partly as a result of the police strategy of attempting to reduce drug use by reducing the availability of needles. In 1985 Muirhouse Surgery in Edinburgh found that half of their sample of injecting drug users was infected with HIV.

The GP response

Local GPs started to prescribe substitute opiates to their drug using patients in an attempt to reduce the drug related harm they saw presenting in their surgeries. A Facilitator Team of doctors and nurses was formed in 1989, initially to offer support and training to primary care staff caring for HIV infected patients. With time the remit evolved to include caring for drug users and by 1995 over 1500 drug users were receiving prescriptions from their GPs. A scheme was then launched to remunerate GPs for this work in return for requiring them to implement guidelines on assessment, care and prescribing, and for this work to be audited. This was an innovative response which helped inform the National Enhanced Service incorporated into the 2004 General Medical Services GP Contract. The current shared care model in Lothian sees most patients referred by their GP to locally based assessment clinics staffed by a mix of secondary and primary care clinicians working along side the voluntary sector. Patients are assessed and triaged with the majority returning to their GP surgery, after a period of stabilisation, for ongoing care and treatment. There are now almost 4000 patients receiving their drug treatment from their local GP surgery, supported by software providing clinical management screens and data analysis. Over 70% of these patients are being prescribed methadone.

> ***"Patients have access to locally available drug care at their surgery and with doctors and nurses with whom they are likely to already have therapeutic relationships"***

There are many benefits to this model and the fact that practices need to opt into doing this work goes some way towards ensuring that practice teams are motivated to carry it out and maintain the expertise to do so. Patients have access to locally available drug care at their surgery and with doctors and nurses with whom they are likely to already have therapeutic relationships. They can avoid the stigmatisation of attending a specialist drug centre whilst having easy access to all the other services available in primary care including health promotion and chronic disease management expertise. Referral, or signposting, to locally based community resources is easier with more likelihood of engagement. The complexities of patients' social and family lives are likely to be known to team members making sharing of information easier.

Potential disadvantages

Practices need to feel supported by their specialist service with the knowledge that help is at hand if problems develop. Lack of resources in secondary care and long waiting times can leave GPs feeling exposed. Good communication and an identifiable specialist from whom to seek advice are important. The GP is likely to become the main source of professional support, particularly for patients who have been in treatment for some time or who find it difficult to maintain contact with other agencies. This is different from *key working* and is a potential gap in service provision. Good therapeutic relationships, however, are known to be important in achieving good outcomes and GPs should be well placed to develop these and provide a continuity of care often lacking in other services.

The future

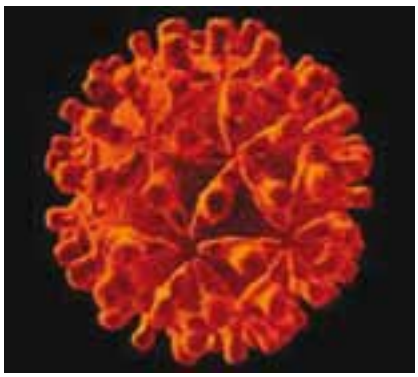
'GPs clearly have a key role to play in promoting recovery from problem drug use. In addition to dealing with the general health issues of drug users, including medical conditions that stem from drug use, GPs can provide specialist care for drug users under the National Enhanced Service specification including coordination of care, substitute prescribing and procedures such as hepatitis testing and immunisation as well as referral on and liaising with appropriate support services'[1]. The auditing of GP care in Lothian shows ever improving evidence based prescribing and uptake of blood bore virus testing and hepatitis immunisation. Contracted practices are supported by regular audit feedback and practice based training tailored to individual practice needs as well as locally produced updates and guidelines. They are well placed to take forward the recovery agenda whilst remaining rooted in the basics of harm reduction.

Charles Lind, Consultant Psychiatrist, NHS Ayrshire and Arran

David Ewart GP and Medical Facilitator (Drugs), Primary Care Facilitator Team, Substance Misuse Directorate, NHS Lothian

Ewen Stewart **explores the different responses of the English and Scottish policy makers to prevent the harms associated with hepatitis C infection. Ed.**

Tackling hepatitis C – have we got it right?



Introduction

Overall, it is estimated that around 185,000 individuals in the UK are chronically infected with hepatitis C (HCV) and that current or former injecting drug users (IDU) make up the large majority of this population. Around half of estimated cases of hepatitis C infection have been diagnosed, an improvement on the high proportion of undiagnosed patients in 2004, but still a worrying figure as those who are undiagnosed will not be accessing treatment and may be unwittingly spreading infection. Over the past decade there have been differing policy approaches in Scotland and England to prevent the harms associated with hepatitis C infection. This article aims to summarise the findings of these policies, and to compare and contrast the English and Scottish approaches and outcomes.

Prevention

Policy in England since 2004 has focused on improving access to community drug treatment as well as increasing accessibility of needle and syringe programmes (NSPs). Services were asked to include the provision of needle, syringe and other injecting equipment in the community and also to provide peer education[1]. However, in 2009 the Hepatitis C Trust report *'Out of Control'*[2] found that six of the ten Strategic Health Authorities in England had no local arrangements in place to review and strengthen harm reduction services, including needle exchanges and the All Party Parliamentary Hepatology Group report *Divided Nations: Tackling the hepatitis C challenge across the UK*[3] strongly criticised the lack of monitoring and accountability of the English action plan which it felt had lead to poor implementation.

In Scotland the emphasis has also been on increasing and improving injecting equipment provision and on developing educational initiatives to reduce risk behaviour. However in contrast to England, funding for both has been allocated through the action plan and strict governance procedures are monitoring implementation in each health board area. New national guidelines in Scotland will radically alter the provision of injecting equipment provision (IEP) services including provision of colour coded equipment, increases in the amount of all injecting equipment given out and blood borne virus testing at IEP sites.

In both countries prevalence of HCV in IDU remain high, being estimated to be 41% in England and 53% in Scotland, with significant local variations. The effectiveness of both policies still needs to be monitored, especially as the Scottish plan is only just entering its second year. The accuracy of the data available also needs to improve, and the Health Protection Agency and Health Protection Scotland are currently working on improving the information available on HCV incidence.

Awareness raising

Diagnosing new infections is important for individuals to allow them access to treatment, but it is also a vital part of the public health campaign to reduce new infections. Achieving high testing rates is dependent on professionals, especially in primary care and community drug clinics, being pro-active in recommending and performing screening tests for the virus. In both England and Scotland awareness campaigns aimed at professionals and the public (in particular IDUs and South Asians) have been integral parts of the action plans. The English campaigns are well established but the Scottish one was delayed by swine flu activity and has only just been launched. The success of the campaigns will be judged using measures such as increases in laboratory reports of confirmed infection and surveillance of increased testing in specialist drug clinics. In Scotland the action plan has also required each NHS board to appoint a workforce development and education lead to address the learning needs identified in a survey of the workforce.

> ***"A major increase in those receiving the effective treatment that is available is essential to reduce the substantial burden of hepatitis C-related disease for infected individuals and society as a whole"***

Increasing diagnosis

One of the outcomes expected from increasing public and professional awareness is an increase in the number of people diagnosed with HCV infection, reducing the proportion of those infected who are unaware of their infection. Already across the UK rates of diagnostic testing and the number of newly diagnosed individuals are increasing.

In England evidence suggests that almost 70% of IDUs presenting for treatment are now offered an HCV test and that use of oral testing has significantly contributed to achieving this level. In Scotland the action plan requires NHS boards to implement a local plan, which incorporates innovative approaches to HCV testing, designed to improve testing and referral activities in GP and community settings. Oral testing is not widespread in Scotland but dried blood spot testing and near patient tests are being used. At needle exchanges 77% of IDU report having been tested for hepatitis C and 36% had been tested in the last year.

In all areas the normalisation of testing for blood borne viruses (BBVs) is crucial to achieving the numbers required. Testing for BBVs must be seen as integral to the care of past and present IDUs wherever they are seen, and it must be

1 Department of Health (2004) Hepatitis C: Action Plan for England.

2 Hepatitis C Trust (2009) Hepatitis C: Out of Control: An audit of Strategic Health Authority hepatitis C governance

3 All Party Parliamentary Hepatology Group (2009) Divided Nations: Tackling the hepatitis C challenge across the UK A report of a meeting of the All-Party Parliamentary Hepatology Group, 18 November 2008, House of Commons

the responsibility of each professional to raise, discuss and ensure that these tests are taken when consent is obtained. Data needs to be collected on testing in community settings to monitor effectiveness of interventions.

Treatment and care

A major increase in those receiving the effective treatment that is available is essential to reduce the substantial burden of hepatitis C-related disease for infected individuals and society as a whole. At present the incidence of HCV-related severe liver disease presenting to clinical services is continuing to increase year-on-year across the UK. However treatment rates remain poor: in 2007 only 29% of patients diagnosed with HCV were treated with National Institute for Clinical Excellence approved antiviral therapy.

In Scotland the number of patients given HCV treatment is monitored on a national database and data is kept on the number of patients referred to specialist services. This has allowed the action plan to set specific targets for increasing the numbers of patients being treated in each NHS board area. The targets were set at such a level as to have an impact on reducing the epidemics of infection and of severe liver disease. Although the targets were exceeded for the first year they have been delayed for subsequent years as it became apparent that they were not likely to be met for year 2. The resources required to meet the targets, both in terms of increased testing, referral and treatment services, were identified and funded by the Action Plan but the realities of implementing the plans and recruiting necessary staff were complex. It is anticipated that the targets will be met after this one year delay.

In contrast, England requires primary care trusts to develop mechanisms to monitor the numbers of people being referred and treated in order that the success of interventions to increase the numbers in treatment can be measured.

In conclusion

It appears that there is currently little coordination of implementation of the English Hepatitis C Action Plan. Both the HPA[4] and the Hepatitis C Trust are clear in recommending that strategic health authorities should be taking a lead in this area. They also call for primary care trusts to ensure that integrated care pathways and clinical networks are developed for patients with hepatitis C.

The implementation of the Action Plan for Scotland is monitored using a project management approach with locally managed care networks feeding back into Health Protection Scotland. An Action Plan Governance Board with representatives of lead organisations supervises the reporting process and an Advisory Board advises on Action Plan delivery. It remains to be seen whether this approach will be more successful in achieving the ultimate outcomes of preventing new infections and increasing the numbers of those infected who are treated. The other significant difference in Scotland is the provision of significant specific funding for hepatitis C prevention and treatment. It may be this that ultimately leads to divergence in the success of the two action plans.

Ewen Stewart, Chair RCGP Sex, Drugs and HIV Group and GP Edinburgh

4 Health Protection Agency (2009) Hepatitis C in the UK: 2009 Report

One of the many issues that prevent improvement in the detection and treatment of HCV is lack of training. In light of this the RCGP and SMMGP are currently developing 'The RCGP Certificate in the Detection, Diagnosis and Management of Hepatitis B and C in Primary CareÅf in 2 Parts: Part 1 aims to help improve detection and testing rates and Part 2 aims to increase access to treatment. The course will be ready to go live in about 1 year.

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The RCGP Certificate in the Management of Drug Misuse Part 1: the story so far

the Part 1 was aimed at practitioners who had any contact with drug users in primary care. It did not profess to train specialist practitioners, instead providing an overview to the principles of treatment, and to harm minimisation strategies and their importance. In this way, it was hoped that the Part 1 would play a significant role in the drive to move drug treatment from the periphery to the heart of primary care. Prior to its' existence, there was no comparable national validated training set at this entry level to treatment, and this lack of opportunity had certainly contributed to the marginalisation of drug treatment as a whole, particularly in general practice.

With these principles in mind, and with the support of the RCGP and the network of multi-disciplinary specialists working in shared care settings, the Part 1 quickly became established as the entry level course for drug treatment in primary care. With a rapidly established network of local trainers, co-ordinated centrally, the course was being successfully delivered (and spreading the word!) soon after its inception.

Many of the Part 1 alumni go on to develop their interest and progress to the Part 2; others use it to bolster their knowledge in the field and take this insight back to the primary care coalface. Course participants gain confidence and expertise, and transfer renewed enthusiasm back to their workplace; the beneficiaries must surely be the clients themselves.

We must all continue to maintain our training to a proficient level, and the Part 1 ensures that there is high quality validated and standardised training across the disciplines nationwide. It truly is a flagship training programme for the RCGP and within the field of substance misuse as a whole. If you have not yet undertaken it, the mere fact that you are reading *Network* means, I am certain, it would be appropriate for you!

Look us up at: http://www.rcgp.org.uk/practising_as_a_gp/substance_misuse.aspx

Or contact: **Part One Coordinator** Lorna Boothe lboothe@rcgp.org.uk **Part One Clinical Lead** Martyn Hull marthull@hotmail.com

Martyn Hull Part 1 Clinical Lead and GPSI Birmingham

Mark Gilman **describes the process that the North West Region has gone through to develop treatment systems that have at their heart the recovery of service users. He suggests that whilst harm reduction is a central part of treatment, we must allow services users to take risks to achieve their goals. Ed.**

Recovery Oriented Integrated Systems in the North West

In 2005 the North West Region set out on a journey to discover what the 22 drug treatment systems in the area might look like if they embraced a recovery orientation. This pilot ended in November 2008. One of our partner agencies, 'Genie in the Gutter'[1] has made a film record of this journey. The DVD "Once Upon A Time in the North West" is available from Genie in the Gutter.

Recovery oriented

Debates about definitions of recovery are interesting but they are a time wasting cul-de-sac on the road to recovery. Recovery demands action not debate. You are in recovery if you say you are. Let's get on with it. We took this approach from Phil Valentine and our colleagues and partners in Connecticut Community for Addiction Recovery (CCAR)[2]. This definition is all you need to get moving and get some recovery traction. The situation we set out to change was the stagnation that is characteristic of too many treatment systems. The introduction of a Recovery Oriented Integrated System (ROIS) is a way to improve these systems, remove the blockages and introduce a healthy flow of fresh, clean recovery optimism. Within the first year of developing ROIS we could see recovery optimism replacing pessimism. We want clients to be energised by the experience, strength and hope that comes from exposure to fellow addicts and alcoholics in recovery. It has worked. We have seen miracles happen in the North West. Currently, recovery is most evident in Merseyside. The Wirral is recovery central. On the Wirral most of those in recovery have come via community drug teams and opioid maintenance. The Wirral has shown that the NHS can do recovery.

Integrated systems

We chose the acronym ROIS because of the need to have an integrated system. Commissioning is the vehicle that can create the architecture of a recovery oriented system. One would hope that all services in a drug and alcohol action team area would want to work together in a recovery oriented system. Unfortunately, this is not always the case and in these circumstances, commissioners may have to utilise performance management frameworks, contracting, market testing and re-tendering to address stagnation. Any new prospective recovery oriented providers would be well advised not to rely solely on referrals from other parts of the system. In developing ROIS, we saw instances where stagnation was unwittingly encouraged. We have all heard the classic tales of clients who ask for detox and rehab and are told they are not ready. What about clients who are making good progress but are halted in moving on to the next stage in their recovery journey? For example, we heard of cases where people were stabilised on maintenance medication and had managed to secure employment. When they asked to reduce their medication (which they saw as the next logical step) they were advised they were being hasty and it was suggested they stay on the same levels of medication. Instances such as this are not the work of malice. Doctors and workers who give this kind of advice mean well. They have been taught to reduce risk and minimise harm. But even the best harm reduction message can be received as demoralising and patronising. Worst of all it can suffocate ambition and aspiration.

> ***"even the best harm reduction message can be received as demoralising and patronising. Worst of all it can suffocate ambition and aspiration"***

When we teach our children to ride bikes we all get to the point where we take off the stabilisers and hold our breath as the loves of our lives wobble off down the street. If they fall off we comfort them and let them try again. Eventually, with a few scuffed knees, they peddle off into the distance and we are immensely proud. When we tell clients to stay on their medication it can be like telling our kids to keep the stabilisers on. We run the risk of treating adults as children. In an effort to reduce harm we can stifle adult self direction. There *is* a risk of overdose and there is no recovery in graveyards. But life is made up of risks. About 2 years into the North West pilot one of our recovering colleagues relapsed and died from an overdose. It was very upsetting and doubt set in. It was easy to imagine the critics of recovery saying "there you go that's what happens with this recovery business; people die". However, we were reminded that he had died after making his choice to try a different way. The stakes were high but the prize on offer was massive. He was treated with dignity and although he lost his personal battle for recovery he has inspired many others to try.

Recovery communities

Personal recovery from drugs and drink also has real benefits for families and communities. It is the people with the least who have the most to gain from recovery. Moreover, Prolific and Priority (drug driven) Offenders (PPOs) have been at the forefront. Many of those now in recovery in the North West were involved in criminal activity before they developed substance use disorders. Prior to the development of ROIS some of this group used maintenance medication as a leisurely start to a day of further offending to raise cash for heroin and crack. Some medication based treatments struggle to hold them and keep them out of prison. In the North West, a proportion of PPOs are now embracing total abstinence 12 Step treatment programmes and 12 Step mutual aid (Narcotics Anonymous and Cocaine Anonymous). SMART recovery[3] is a working alternative to 12 Step programmes and may be getting similar results. Recovery in the North West is a community thing. We are now being heavily influenced by Asset Based Community Development (ABCD)[4]. In the world of ABCD, recovering addicts and alcoholics become an asset to any community. The final word has to go to Damien Prescott of Wirral Drug Service and one of the recovery pioneers in the North West[5].

"It is a beautiful paradox that those who have been for so long stigmatised as the source of so much damage and disharmony are now becoming the agents of renewal, rebuilding and transforming the communities where they live."

Mark Gilman, National Treatment Agency for Substance Misuse, North West Regional Manager

1 http://www.genieinthegutter.co.uk/

2 http://www.attcnetwork.org/learn/topics/rosc/docs/phillipvalentineinterview.pdf

3 http://www.smartrecovery.org/

4 http://www.abcdinstitute.org/

5 Personal communication

Insomnia can be one of the most difficult obstacles to a successful detox, and is generally a common problem amongst substance misusers. *Peter Balfour, Pam Wells* and *Christine Ramsden* outline their experience of dealing with insomnia in an acute setting, and provide guidance which may prove very useful to service users in a community setting. Ed.

Dealing with insomnia in an acute detoxification unit

Complaints of poor sleep are common among substance users who are detoxing from opiates. When someone in an acute detoxification unit complains of poor sleep and asks for (or demands!) a sleeping tablet, how should one respond? At the end of the day, though it can be very difficult when detoxing, not sleeping for a few nights is not detrimental to health and hypnotic drugs are best avoided whenever possible – to discourage the belief that chemical "quick fixes" are good ways of managing difficulties. The pattern of sleep (or lack of it) helps guide management and it is important to check with night staff that the amount of sleep reported equates with what has been observed because perceptions of how much sleep one is having are often distorted. If difficulty in sleeping is reported, sleep hygiene should be discussed with patients and it is suggested that the following points are covered:

Stimulants: avoid caffeine-containing beverages such as tea or coffee (as well as medical or recreational stimulants and alcohol) after, say, four-o'clock in the afternoon and avoid smoking or excess eating for an hour before retiring[1] [2].

Loud noise and other disturbing environmental stimuli (such as bright light or lack of fresh air) can also disrupt sleep[3].

Exercise or adequate engagement in structured daily activities lead to physical (and sometimes mental) tiredness - which usually help sleep.

Easing the mind encourages restful sleep - maybe by having a bath or milky drink, reading, reviewing the day's activities/ planning how to address future problems and/or praying before retiring (perhaps with help from a staff member initially).

Pain and symptoms such as itching may respond favourably to analgesics or sedating anti-histamines (such as chlorphenamine[4]).

Expectations: a "normal" amount of sleep may be anywhere between four and nine hours[3] but, because people often become anxious if they think they need more than they are actually having, simple explanation may have an important role.

Routines need to be regular – Semple et al recommend going to bed when tired (initially) and then going to bed at such a time that getting up within an hour of the same time every day (including at weekends) is comfortable[2]; daytime naps of significant length (more than 10 minutes) should be discouraged.

Stretching exercises (such as trying to touch the toes while the legs are kept straight) before retiring may prevent legs becoming restless during the night.

Specific reasons for a patient's insomnia should be considered. Initial insomnia may be due to idling in (or out of) bed earlier in the day and establishing a routine can often help this (for example by asking people to be up by a certain time every day and/or arranging activities at specific times during the day); interrupted sleep may be due to underlying physical disease (requiring specific treatment) and early morning wakening is often a symptom of depressive illness (although factors such as daylight coming through a window on a summer morning might need consideration) – in which case an antidepressant may be indicated.

If causes such as these have been excluded, Semple et al recommend getting up after 10-20 minutes of trying to sleep, going into another room, doing something relaxing until sleepiness returns, and only then going back to bed[2]. Cat-napping during the day can also lead to interrupted sleep during the following night and should be discouraged (although resting quietly with one's eyes closed for a few minutes does not usually cause problems).

Reassurance and support may be all that is required, but occasionally medication may seem warranted (for example when patients threaten to take their discharge if not given a drug to help them sleep). A short course of sedative antidepressant may be the best choice (for example, mirtazapine is known to have a marked sedating effect when taken at low doses or initially[4]) but, as a last resort and very occasionally, chloral hydrate or zopiclone may be tried on non-consecutive nights.

Having gone to bed, a person may find it helpful to intermittently concentrate on relaxing muscles (that have tensed up unconsciously), for example, by deliberately tensing those muscles (briefly) and then relaxing them, and avoiding clock-watching (for example by turning the clock face towards the wall) allows many people to relax better.

Peter Balfour (ex-Locum Speciality Doctor), **Pam Wells** (Staff Nurse) and **Christine Ramsden** (Retired Nursing Sister) Newhouse Drug and Alcohol Unit, Shrewsbury

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1 BMJ Learning on-line module: Depression in adults: in association with NICE http://learning.bmj.com/learning/search-result.html?moduleId=10013862

2 Semple D et al (2005) "Oxford Handbook of Psychiatry", Oxford University Press Inc., New York.

3 Wells, P (2008) "Sleep Information Brochure" and "Sleep Policy", in-house publications, New House, Shrewsbury

4 Royal Pharmaceutical Society of Great Britain "British National Formulary 56" (2008), BMJ Group and RPS Publishing, London.

We are pleased to introduce our first Dentist Fixit! *Chris Cunningham* offers advice to a GP who is struggling to find treatment for their patient who is homeless. Ed.

Dentist Fixit on opioid dependence and dental pain

Dear Dentist Fixit,

Billy has been a patient of mine for about 6 months. Although he is 36 years old he had never been in treatment before. He was homeless and had been injecting heroin and cocaine for a number of years. He loves to play the guitar but has stopped doing so due to the dental pain he is experiencing. His goals when coming into treatment were: 1) to stop injecting, which was achieved fairly quickly and he is now maintained on 100mg of methadone and is using no drugs on top 2) to become housed, which was slightly more difficult, but he is now in a stage one male hostel from where he will move on to a supported flat in about 6 months time and 3) to sort out his teeth which is what I need your help with as we have not progressed in this area. He has chronic viral hepatitis C and previously we have managed to get the HIV dentist at the local GUM (genitourinary medicine) clinic to see our patients but this post has unfortunately been cut. We have tried several local dentists and they all seem to have closed lists, or don't do NHS work. We did get him an appointment to see one dentist but Billy was sent away as he was 10 minutes late. The dental hospital refuses to take GP referrals so at the moment we are stuck. Billy has severe caries causing him pain and I am concerned that his teeth are his biggest relapse risk.

I have attempted pain relief but it is not very effective so can you help me by explaining: why dental caries are so common in people who use drugs; why the current dental system seems to fail people like Billy; what is the most effective pain relief; and any ideas how I can get treatment for this wonderful guitar player?

Answer provided by Chris Cunningham, Assistant Clinical Director, Lothian Salaried Primary Care Dental Service

Firstly can I say how sorry I am that you are having difficulty finding a dentist for Billy. National Health Service General Dental Practice (NHS GDP) really doesn't work well for patients with chaotic lives and complex medical histories like his. In defence of NHS GDPs they are trying to efficiently run very busy small businesses whose payment system is based around a large throughput of patients. People who cannot turn up on time for their appointments or whose complex medical stories require extra time to consider, followed perhaps by liaison with physicians or GPs to clarify any concerns, are not what dental practitioners term "practice builders". That is why primary care trusts and health boards employ salaried dentists in order to offer treatment to people who have difficulty accessing mainstream NHS dental practice and I would suggest you contact the Clinical Director of your local salaried primary care dental service (known as the Community Dental Service) to see if they can suggest a referral route for you.

As you have noticed with Billy, it is very common for people who have been using opiates for a long time to develop severe tooth decay. Commonly the methadone itself will be blamed but it is not that simple. Studies have shown that long term opiate usage causes a marked physiological sugar craving which is demonstrated by hugely increased quantity and frequency of added sugar in their daily diet to which, frankly, a single daily dose of methadone whether it is sugar-free or not, contributes very little. In addition all opiates including heroin, methadone, other opioids such as dihydrocodeine and over the counter medications containing codeine have a side effect of causing a marked decrease in saliva production so that the acid produced in the mouth by these dietary sugars is not washed away as quickly as usual. If, on top of this, you then accept that chaotic drug users are not brushing their teeth or visiting a dentist regularly it is not surprising that tooth decay can progress very rapidly. Often the pain and discomfort is masked initially by the opiate analgesia but then breaks through as they reduce their opiate dependence. Often patients (and dentists) are surprised to find that nonsteroidal anti-inflammatory drugs or paracetamol work well even for people on high levels of legal or illegal opiates. These analgesics work via quite different pathways to opiates and, especially when alternated 3 hourly, will manage most dental pain (care should of course be taken in prescribing either of these analgesics to people with advanced liver disease or gastro-intestinal problems). Antibiotics have no effect on dental pain and should not be prescribed unless there is clear evidence of frank infection.

In addition, due to their poor oral hygiene and high incidence of smoking, chronic gum disease is common. If the individual is in anyway immunosuppressed due to poor nutrition or HIV then acute bacterial gum infections can supervene which are characterised by acute, non-localised pain, halitosis and ulcerated gums which bleed spontaneously. The best treatment for this is a short (3 day) course of metronidazole however this is contraindicated with alcohol and so any other broad spectrum antibiotic can be substituted such as amoxycillin. The difficulties drug users face in following oral health promotion advice and accessing mainstream dental services is well demonstrated in a qualitative study published in the British Dental Journal[1].

Drug users and homeless people often avoid dental care altogether due to access problems and embarrassment about the state of their mouths and only attend for emergency care when the pain gets too bad and usually have the offending teeth extracted. In Edinburgh some years ago, in an effort to reduce the barriers to care for homeless people and drug users, we started offering treatment in venues where our target audience might be found anyway! This included a central needle exchange/methadone prescribing clinic and a homeless "one stop shop" where there is health care and housing advice. Importantly, in theses dedicated dental clinics, access to treatment is initially via a drop-in system which is first come first served. All NHS dental treatment is offered including fillings, dentures, crowns and bridges if appropriate. Patients needing extensive treatment will be offered appointments if they wish but with the clear understanding that missing these appointments without notice will result in them only being offered care in the future via the drop-in session. This informal contract with the clients has greatly reduced the number of broken appointments from a level of around 30% before we started the drop-in service.

1 P. G. Robinson, S. Acquah and B. Gibson. Oral health-related attitudes and behaviours of drug users. British Dental Journal 2005; 198: 219–224

Our service is closely integrated with the harm reduction team and homeless support teams and contributes, we feel, greatly to the process of increasing self esteem as part of the long term care and rehabilitation of our clients.

I hope this is some help in explaining why Billy has such major dental problems. You may find it helpful in getting dental care for him and lobbying for dedicated dental services for drug users and homeless people in your area.

Finally I must suggest, speaking as a dental professional, that I would prefer that Billy didn't imitate Jimi Hendrix by playing the guitar with his teeth!

Mick Webb **and** ***Gordon Morse*** **are Dr Fixit to a GP who is trying to support a patient who is using amphetamines. Ed.**

Dr Fixit and amphetamine use

Dear Doctor Fixit

Tanya came to see me last year asking for help with her amphetamine problem. She is 26 years old and first started taking speed orally in her late teens. She found it helped with her late night studying and then began to use it to get through her shifts as a care assistant in an old people's home. But about 18 months ago she realised that she needed more and more for the same effect and changed to injecting. She is now injecting 2-3 times a day, getting into debt and is at risk of losing her job because of frequent days off, arriving late for shifts and odd behaviours. She is desperate to stop and has even tried using heroin and Valium to see if they would help, which they didn't, but she is worried that they could also become a problem if she can't get help.

I've been working with heroin users for about 3 years, have done the Royal College of General Practitioners Certificate in the Management of Drug Misuse Part 1 and am comfortable prescribing methadone and buprenorphine but have never prescribed amphetamines. I turned to the 2007 Clinical Guidelines[1] for help and it sounds like I should not prescribe amphetamines, and I also asked our local consultant who is usually very helpful and he said the same: 'don't do it'.

I want to help Tanya who is extremely motivated to stop all drug use. Can you please help me and suggest how I can treat her, what I should prescribe and how? Thank you

Answer provided by Mick Webb Shared Care Worker, South Gloucestershire Drug and Alcohol Services and **Gordon Morse** Clinical Lead, Turning Point

It is fantastic that Tanya has already disclosed to you her amphetamine use. It is so often the case that a client may present with all the side effects from stimulant use yet neglect to mention the actual use itself.

This first thing to clarify would be what Tanya's intentions regarding her amphetamine use are. Is she looking to regain control so use isn't so problematic? Or is she looking to quit completely? These two approaches may require different strategies. In the first instance, to encourage an understanding of how amphetamine works, the role of adrenaline, and why it makes us feel as it does can often make sense of the irritability, sleeplessness and paranoia. In addition to this, to understand the role of dopamine and how it informs our decision making process may also go some way to understanding why she wants to take the drug, while knowing the experience has ceased to become enjoyable.

If her intention is to regain control, then a sensible diet rich in tryptophan and tyrosine (although these amino acids can compete) and hydration will immediately provide relief. You could also to discuss in detail what form the amphetamine is bought in, for example, is it street powder or base? You could suggest that she begins to take control over the purity by mixing measured amounts of either glucose or lactose BP to weaken the concentration, while providing the same volume (a bit like a self imposed blind reduction). The RCGP 8 point health check[2] would also be useful, particularly in identifying arrhythmia and other health problems stemming from amphetamine use.

Referring to drug agencies with a harm reduction service and needle and syringe programme, as well as putting her in regular contact with workers who may have specific knowledge around stimulants and safer injecting could be beneficial.

There is evidence emerging regarding the effectiveness in prescribing amphetamines, particularly if it is an integral part of a care package with the aim of assisting the client to move away from injecting drug use, but generally these are using sustained release dexamphetamine currently unavailable in the UK.

If she is looking to stop amphetamine use altogether then an option may be a very short term Valium prescription which may help with the withdrawal syndrome (30mg or less for 1-2 weeks reducing to 0mg) and for her to be clear as to what to expect during this time regarding lethargy, low mood, increased appetite and the other symptoms of withdrawal from stimulants. There are detox facilities offering stimulant respite, usually around a 2 week residential stay where clients are able to detoxify with appropriate clinical support.

Community detox may be supported with fortifying drinks such as ensure plus, gelatine based vitamins (which are easier on the stomach) dioralyte sachets to help replace the sugars and salts, along side complementary therapies such as auricular acupuncture and meditation classes.

Encouraging engagement with local stimulant services, or a 12 step organisation such as Narcotics Anonymous or Cocaine Anonymous (meetings can be found on the internet) may be the way forward in stepping away completely from all drug use, as well as engaging with services already implementing the evidence based approaches using cognitive behavioural therapy, motivational interviewing, and solution focussed therapies.

It may be useful to gather more information from Tanya regarding her social networks and how these may need to be developed, and other interests and hobbies she may have; anything that may reignite some positivity and love of life.

1 Department of Health (2007). Drug misuse and dependence: guidelines on clinical management 2007.

2 Royal College of General Practitioners (2004) Guidance for Working with Cocaine & Crack Users in Primary Care http://www.smmgp.org.uk/html/guidance.php

CONFERENCES AND EVENTS

The UK/European Symposium on Addictive Disorders (UKESAD)
Building Bridges: How to Recover from Addiction
Date: Thursday 13 - Saturday 15 May 2010
Venue: Grange City Hotel, 8-14 Cooper's Row, London EC3N 2BQ
For more information please contact:
Melissa Gordon or Suzanne Gooch
Tel: 020 7233 5333
Web: www.ukesad.org

Women and Children First:
Supporting Female Substance Misusers and their Families
Date: Tuesday 25 May 2010,
Venue: Audrey Emerton Building, Brighton
Cost: £120 per person including lunch and refreshments
For more information or to book a place please contact:
Brighton Oasis Project
Tel: call (01273) 696 970
E-Mail: info@brightonoasisproject.co.uk
Web: www.oasisproject.org.uk

Mental Health & Substance Use:
Making Integrated Care in the Criminal Justice System a Reality
Date: Tuesday 25 May 2010, 10am-4.30pm
Venue: ORT House Conference Centre, 126 Albert Street, London
For more information please contact: Pavilion Tel: 0844 880 5061
E-mail: info@pavpub.com ***Web:*** www.pavpub.com

6th Annual Conference:
Psychotherapy of Addiction
Date: Monday 14 - Wednesday 16 June 2010
Venue: Friends House (Quakers), 173 Euston road, London NW1 2BJ
For more information please contact:
Martin Weegmann (Organiser)
Tel: 07834 430 880
E-mail: martin.weegmann@swlstg-tr.nhs.uk

2nd European Conference of the CONNECTIONS Project
Drugs, Alcohol and Criminal Justice:
Ethics, Effectiveness & Economics of Interventions
Date: Thursday 24 - Friday 25 June 2010
Venue: Friends House, 173 Euston Road, London NW1 2BJ
For more information or to register please see: Web: www.connectionsproject.eu

4th West Midlands SMMGP, RCGP, SCAN & NTA Conference -
Driving Excellence in Local Services: Beyond National Standards
Date: Friday 25 June 2010, 9.30am-4.00pm
Venue: Government Office for the West Midlands, 5 St Philip's Place, Colmore Row, Birmingham, West Midlands B3 2PW
Cost: £35 including lunch and refreshments
E-mail: patricia.wright@nta-nhs.org.uk

SMMGP: 5th National Primary Care Development Conference:
Innovation in an Austere Climate
Date: Friday 15 October 2010
Venue: The Assembly Rooms, Newcastle-on-Tyne
Cost: £164.50 (inc VAT) per delegate
Cost: £270.25 (inc VAT) for two delegates from one organisation
For more information contact Sarah Pengelly Tel: 01920 468856
E-mail: sarah.mpa@dial.pipex.com

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